California's Adult Performance Outcome System Protocols and Answers to Frequently Asked Questions

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Introduction

This document is intended to provide general information regarding California's Adult Performance Outcome System as well as provide answers to the most frequently asked questions. Many of the issues, questions, and even answers were gathered from county mental health clinicians, quality managers, and administrators as well as consumers who have received or continue to receive services from county mental health programs.

Individuals who have additional questions are encouraged to send them to the California Department of Mental Health for inclusion in this document. Additionally, those who submit questions are encouraged to suggest possible answers that should be considered in the establishment of policy relating to that issue. Questions, comments, and suggestion answers should be submitted, in writing to:

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Additionally, questions, comments, and suggested answers may be emailed to:

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System Design Questions

- How was the adult performance outcome system designed?

The California Mental Health Directors Association (CMHDA), the California Mental Health Planning Council (CMHPC), and the Department of Mental Health (DMH) have collaborated on every step of the process for developing California's mental health performance outcome system.

The central feature of the process was the Performance Outcome Advisory Group (POAG). The POAG was comprised of members drawn from the CMHDA, CMHPC, DMH, direct consumers, family members, and representatives of advocacy groups. The POAG, which was a policy level work group, reviewed recommendations from the Performance Outcome Technical Work Group (POTWG) and made recommendations to DMH for final decision. The POTWG was composed of some members of the POAG as well as other individuals with specific clinical, policy, fiscal or data management expertise. The work group was co-chaired by the DMH, CMHDA, and CMHPC and all interested parties were welcome to attend workgroup meetings. Together, these groups attempted to represent a balanced voice from all of the major constituencies. Their recommendations were presented to the DMH which, upon considering the issue from the State perspective, made informed policy decisions.

Once the POAG had completed its function (laying the groundwork for the outcomes implementation process), the group was disbanded. For the next phase, which will concentrate on quality improvement and integrating outcomes and overall system oversight into a seamless system, a new group will be formed, again composed of representatives of the CMHDA, CMHPC, DMH, members of mental health boards and commissions, and the community of mental health consumers and family members.

<u>Development of Adult Performance Outcome Measurement System</u>

Previous Adult Performance Outcome Efforts. The first attempt at collecting performance outcome data was based on a custom-designed survey, the Adult Performance Outcome Survey (APOS), developed by DMH in conjunction with county and consumer representatives. This custom survey was designed to be administered to a sample of seriously mentally ill (SMI) adult clients at a beginning time, six months later, and then again six months after that. Several issues that emerged during this study included the difficulties of maintaining a representative sample and the lack of comparability of the data. Maintaining a representative sample became increasingly difficult as clients would drop out of service, move out of the area, or disappear for other reasons. In order to keep the sample representative, county staff had to spend time looking for these individuals

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which was time-consuming and not particularly cost-effective. Additionally, since the custom-designed survey was only administered to a sample population, clinicians administering the survey found it to be more of an additional paperwork burden than the collection of data useful for treatment planning. And, since the survey was custom-designed and not a standardized instrument, the data were not comparable to data from other states or entities. Comparability of data is becoming increasingly important in an era of national focus on performance measures.

Based upon the results from the APOS, the CMHDA, CMHPC, and DMH established several criteria for future studies. These criteria include recommendations that the data should:

- be useful to clinicians for treatment planning;
- be useful to counties for quality management purposes;
- meet the requirements of the state for performance outcome data; and
- allow comparison of California's public mental health programs with those of other states/entities.

Adult Performance Outcome Pilot. Under the leadership of DMH, and in collaboration with the CMHPC and the CMHDA, nine counties volunteered to participate in a pilot project to assess several instruments for use in the implementation of an adult performance outcome system in California. The pilot counties were: Los Angeles, San Francisco, San Joaquin, San Mateo, Santa Barbara, Stanislaus, Tehama, Tulare, and Ventura. The piloted instruments were evaluated on administrative, psychometric, and qualitative factors. In addition, discussions were held regarding the minimum set of instruments necessary to adequately measure several important quality of life domains. Pilot counties also evaluated the automated or manual data entry/scoring systems they used to report performance outcome data to clinicians, county management, and DMH.

Each pilot county administered a selection of the assessment instruments to a sample of the target population (seriously mentally ill clients, expected to be in service more than 60 days) at time one and then again six months later. Each county then forwarded its pilot data to the DMH for analysis, along with an evaluative report. The report described their sample of clients; the training, selection, and administration procedures used; and provided narrative evaluations of the instruments and data collection/scoring system used. Qualitative evaluations of instruments included: time to administer and score, clinical usefulness of the data generated, usefulness of the data for quality improvement or program evaluation, cultural competence of the instrument, and acceptability to consumers and/or family members. Qualitative evaluations of data information systems included cost of the system, optimal system requirements, ease of the system to set up and use, stability of the system, and customer service and technical support from the developers of the system.

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Recommendation. Using a collaborative process, taking into account the adult pilot results as well as other factors, the POAG recommended the following set of instruments for the Adult Performance Outcome System:

- the Global Assessment of Functioning *(GAF*)
- the Behavior and Symptom Identification Scale (*BASIS-32)*
- a quality of life instrument (**either** the California Quality of Life (*CA-QOL)* **or** Lehman's Quality of Life - Short Form (*QL-SF*)
- the Mental Health Statistics Improvement Program (*MHSIP*) Consumer Survey - (26-item version)

Usefulness to Clinicians

The data generated by the instruments are intended to provide clinicians with a multi-axial or multi-source method of collecting client-relevant data. This information may be used by the clinician to identify specific target areas that are most affecting the client's life and to select appropriate intervention techniques. Additionally, the clinician can evaluate the outcomes of the services he or she provides either to the same client over time or to specific sub-populations of the clients he or she serves. Typically, the data may be used by the clinicians to both supplement and cross-validate their own clinical judgments.

- All of the major instruments (BASIS-32, Quality of Life, and MHSIP Consumer Survey) are client self-reports and are from the client's point of view. The only real input that the clinician has is in the form of the Global Assessment of Functioning (GAF). Why is there so little emphasis on the clinician perspective?

  At the conclusion of the Adult Performance Outcome Pilot Project, it was recommended that another assessment tool, the Kennedy Axis-V subscales be used instead of the GAF. This was because of the fact that the GAF is a unidimensional measure of multi-dimensional traits. The GAF, for example provides a single score that takes into account the entire functional level of the client. Thus, two clients with similar GAF scores could potentially have very different patterns of functioning. However, in an effort to minimize changes that could require more of a clinician's time, it was decided to continue to use the GAF score as the primary method of obtaining the clinician's view of the client's functioning.

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Target Population Issues and Questions

- Who is the target population for the Adult Performance Outcome System?

  Adults with a serious and persistent mental illness, ages 18 through 59, who have (or will) receive services for 60 days or longer—excluding "medications only" clients. Medications only clients are those who, even if they have a case manager, are only receiving services relating to maintaining their medications.

- What if I have a client who has been part of the target population and who has been receiving the instruments, but who now has been transitioned to medications only status?

  In this case, the client would be "discharged" from our target population and so a final (discharge) set of instruments should be completed. As long as the client remains a "medications only" client, the adult performance outcome instruments need not be completed for that client unless your county has decided to include them.

- What if a client who was previously a part of the target population and had completed the instruments but who was discharged to medications only has decompensated and now requires additional county mental health services?

  If the client requires additional services beyond medication, then he or she has become a part of the performance outcome target population. Therefore, at this point the adult performance outcome instruments must be administered. Since the client had previously received county mental health services, this is not an intake episode for the purposes of performance outcomes.

- Why were medications only clients exempted from the Adult Performance Outcome System?

  Ideally, performance outcome systems are designed to measure change in status as a result of services received. After discussions with the California Mental Health Directors Association, California Mental Health Planning Council, and staff at DMH, it was concluded that, since clients who are properly and appropriately medicated are most likely stable, it does not make sense to include them in a system that is designed to measure change. However, it was agreed that over the next several years this issue will be re-evaluated to find out how many people would be missing from the system and to test the assumption that

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medications only clients are in fact stable.

- What if a target population client is being treated out-of-county? Must the adult performance outcome instruments be administered to these individuals?

  Yes. Typically, the instruments will be administered in the county where the client is being seen. Later, once the data have arrived at DMH, they will be associated with the client's county of fiscal responsibility. It is recommended that counties work out contractual agreements that specify the roles and responsibilities of each party as they relate to performance outcome data collection and reporting.

- Must the performance outcome instruments be administered to inpatient clients (e.g., those being served in IMDs)?

  Most clients who are seen within a county on an inpatient basis do not remain in that setting for more than 60 days. Eventually, they are either referred to a state hospital or begin being seen on an outpatient basis. Either way, the final definition that should be used to decide who receives the instruments and who does not is based on whether or not the client receives services for more than 60 days.

- If a client has been admitted to county services on an inpatient basis, when do the 60 days begin during which the instruments are to be administered -- the date of admission to inpatient services or the date the client was discharged to outpatient services?

  Ideally, it would be best to administer the instruments as early as possible—even if the client was in an inpatient placement. This is because the county's data would then capture the change data for the client that would include their true level of functioning when they first received county services. This will have the effect of ensuring that the county would be able to fully demonstrate the positive outcomes that are resulting for these clients.

  However, administering the instruments in the inpatient setting could be difficult for a variety of reasons. Therefore, for the official State DMH Adult Performance Outcome System standpoint, the 60-day time period is to begin when the client is admitted to the county's outpatient program.

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- What do I do if I am not sure whether or not a person is part of the target population and should be administered the performance outcome instruments?

  It is impossible to develop protocols that deal with every possible specific situation. There are a lot of gray areas. In the end, DMH will compare the data received from counties with estimates of the number of target population clients that DMH records show should be part of the performance outcome system and investigate large discrepancies. The standard is to do the best that you can. Should you have any questions regarding a specific situation, DMH staff are available to help you. For questions relating to the Adult Performance Outcome System, call Karen Purvis at (916) 653-4941.

Instrument Administration Schedule and Protocols

- How frequently are the adult performance outcome instruments to be administered?

  Essentially, the instruments are administered once each year. They are to be administered at intake, annually thereafter, and at discharge.

- Exactly what do you mean by "Intake"?

  For the purposes of the performance outcome system, the term "intake" refers to the first 60 days during which the client receives services. This time period is essentially the same as the amount of time that could elapse before a coordinated care plan was to be developed. So, when a client first begins receiving county mental health services the "clock" starts ticking.

  The instruments should be completed during the first 60 days of services. An important point should be added here. While it is permissible to wait until the 60^{th} day of service before administering the instruments, this is certainly not the best way to approach it. Our research, as well as anecdotal reports from clinicians, indicates that very frequently the most dramatic changes occur in the client's functioning during the early days of treatment. Therefore, in order to most accurately measure the effect of county mental health services, it makes sense to administer the instruments as early as possible.

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- Are all of the adult performance outcome instruments administered each time?

  No. The Mental Health Statistics Improvement Program (MHSIP) Consumer Survey is not required to be administered at intake. This is because it is assumed that clients have not had enough experience with the program to rate it reliably. The table below identifies when each instrument should be administered.

Schedule of Adult Performance Outcome Instrument Administration		
Intake	Annual Administration	Discharge (Either from county services or to medications only status)
• Client Identification Face Sheet • GAF Score (Reported through CSI) • BASIS-32 • Quality of Life Survey (Either CA-QOL or QL-SF)	• Client Identification Face Sheet (For existing clients who have never completed the outcome instruments) • GAF Score (Reported through CSI) • BASIS-32 • Quality of Life Survey (Either CA-QOL or QL-SF) • MHSIP Consumer Survey	• GAF Score (Reported through CSI) • BASIS-32 • Quality of Life Survey (Either CA-QOL or QL-SF) • MHSIP Consumer Survey

- What about clients who are currently being seen in our county mental health system? Do I have to administer the instruments to all of them immediately?

  No. For clients who are currently in the system, they should be administered the instruments when they come in for their next annual review.

- Does the annual administration of the instruments have to take place **exactly** 12 months after the intake set was administered?

  No. It is assumed that sometimes a client might come in for services slightly before or slightly after the 12th month. Therefore, a window has been identified during which it is assumed that the annual set of instruments will be administered.

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This window is from 10 to 14 months after either the intake set of instruments was administered or the last annual set of instruments was administered. This should allow sufficient time for a clinician to meet with the client and provide any assistance that is necessary to ensure that the instruments are completed.

- What if my program wants to administer the MHSIP at intake as well as annually and at discharge?

  There is nothing that restricts you from using the MHSIP at intake. However, the State requirement is for administration only annually and at discharge.

- Can the adult performance outcome instruments be administered more often than annually?

  Yes. Some counties have found it useful to administer such instruments more frequently than annually. Counties may administer the instruments as often as they like. However, the State requirement is that they be administered, at a minimum, at intake, annually thereafter, and at discharge. This is because, from the state perspective, the emphasis is being placed on evaluating county "systems" and not individual programs within counties.

- Who administers the performance outcome instruments?

  With the exception of the Global Assessment of Functioning (GAF), which is completed by the treating clinician, the other instruments (BASIS-32, Quality of Life Survey (Either CA-QOL or QL-SF), and the MHSIP Consumer Survey) are designed to be self-administered by the client. While based on pilot test results, most of our target population clients can complete any one of these instruments in 20 minutes or less with little or no assistance, some clients will require extensive assistance. This could be due to reading skills or functioning levels. When assistance is required, it may be provided by virtually anyone who has been trained to administer them (e.g., peer counselors, clinicians, clerical staff, etc.) **with one exception—the MHSIP consumer survey**. This MHSIP consumer survey must not be administered by the treating clinician. Others who are not providing services to the client may assist, however.

  Whenever assistance is provided to a client in order to complete the instruments, certain procedures should be followed. First, the person assisting should not interpret the items on the instruments. Second, the person assisting should not discuss the client's responses in any way that will affect those responses.

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- What steps should be followed when administering instruments to non-English speaking clients?

  This is a very important question. Part of the answer applies to all efforts to help a client complete the forms. Assistance should be limited to simply reading the questions and marking the client's answers. No effort should be made to interpret the clients responses. This would have the effect of introducing the clinician's (or other person's) bias into the results.

  With respect to non-English speaking clients, there are additional considerations. First, as of the writing of this set of protocols, there are limited non-English translations of our performance outcome instruments available. If there is a non-English translation available in the language of your client, it should be used. If the client is illiterate in their own language, then a translator would be required to read the questions to the client in their native language and mark the answers on an answer sheet.

  If there is no appropriate non-English translation in the client's language, the Community Functioning Evaluation (CFE) should be completed and the outcome instruments would not be administered to the client until such a translation becomes available. The reason for not having a translator translate the instrument "on the fly" to the client is because it is very likely that the instrument will be administered slightly differently each time. This will introduce bias into the data. Additionally, translating instruments so that they are valid and reliable is a very difficult and technical task and should not be entered into lightly. The State DMH will be working with language experts to translate all of our performance outcome forms into California's threshold languages in the very near future. We will begin with the most common languages. Should you have any questions about available translations, please contact Karen Purvis, Adult Performance Outcome Project Coordinator at (916) 653-4941.

- What is the "Link Date" I see on the forms?

  The link date is what we are using to link sets of forms that were administered to a client at a given assessment. It is not necessarily the date of administration or the date the instruments were completed. The specific date that is entered in the link date field is not nearly so important as the fact that **the link date should be the same on each instrument for a given administration**. Some counties are using the client's intake date as their link date. Others are using the date that the coordinated care plan was developed. Still others are using the date that the instruments were scheduled to be administered. Below is an example of four administrations of the instruments to a client beginning at their intake on June 1, 1999 and continuing over the course of three years with a discharge taking place in the third year.

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EXAMPLE OF LINK DATE

Type of Administration	Link Date	Instruments Administered
Intake	June 1, 1999	GAF BASIS-32 Quality of Life
Annual Administration	June 1, 2000	GAF BASIS-32 Quality of Life MHSIP
Annual Administration	June 1, 2001	GAF BASIS-32 Quality of Life MHSIP
Discharge	November 3, 2001	GAF BASIS-32 Quality of Life MHSIP

Note that the link date "day" is the same each year, however, the year for the link date is always the current year. Again, it is critical that the same link date be entered on each of the forms for a given administration.

- What is the best way to ensure that the link date is completed correctly?

  It is recommended that, before the instruments are provided to a clinician for distribution to a client, a clerical staff person enter the critical information on each outcome instrument. This includes: 1) Client Case Number (This is the same number that is reported to the DMH Client Services Information System), 2) County Code, and 3) Link Date. Once this information is entered—especially the link date—the instruments are distributed to the clinician for use.

- Do the instruments all need to be completed on the same day?

  No. Of course, this would be ideal. However, it is not a problem if the instruments are completed over the course of several sessions as long as they are completed roughly around the same time period. This one of the reasons that our link date is so important. Even though the instruments are administered on different days, we are able to identify which ones belong together as a set for a specific client.

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- Why are we required to complete the Client Identification Face Sheet? It seems like it is asking for the same information we report to the DMH in the Client Services Information System (CSI).

  In order to most effectively use the performance outcome data that will result from the administration of the adult performance outcome instruments, it is critical that these data be linked to data in other computer systems maintained by the Department of Mental Health. In order to link the performance outcome data to these other files, certain information needs to be collected that is common to **both** files. That is why the information collected on the Client Identification Face Sheet is also reported to CSI. Performance outcome staff will use Client Case Number, County Code, Social Security Number, Gender, Ethnicity, etc., to help link these files.

- What about the Supplemental Face Sheet? It also collects information that is reported to the CSI. Isn't this redundant?

  As the Adult Performance Outcome System is being implemented, the Client Services Information System (CSI) is also coming on line. The problem is that some counties may not be completely up-to-date in the early period as the CSI becomes fully operational. However, some of the information that will eventually be reported through the CSI is critical to answering the question of how California's public mental health system is functioning. Therefore, the Supplemental Face Sheet is designed to collect that data until your county is fully compliant and up-to-date on its reporting to CSI. Once your county is fully compliant and up-to-date, you will no longer need to complete the Supplemental Face Sheet. DMH performance outcome staff will contact you in writing to let you know when you may stop administering the Supplemental Face Sheet.

- What if my county already collects all of the information that is requested on both the Client Identification Face Sheet and the Supplemental Face Sheet? Do we need to actually use these forms, or can we simply extract the data from our data systems and send that to you instead?

  There is nothing magical about either the client identification face sheet or the client supplemental face sheet. The important point is that the information that they are designed to gather must be reported to DMH. So, if a county is currently collecting this information in an electronic format from which they can extract it and report it to DMH in the format specified by the Adult Performance Outcome Data Dictionary, then the county need not use the face sheets.

  However, if your county is one of the small counties (Those with a population of 50,000 or less) which is using the DMH TELEform system to report your data, then

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the client identification face sheet must be completed and faxed to DMH along with the other adult performance outcome instruments (BASIS-32, Quality of Life, and MHSIP Consumer Survey).

- If a client completes an annual set of instruments and then discharges shortly afterward, do I need to complete a discharge set?

  It depends. Current policy in this matter is as follows: *"If a client completes an annual set of instruments and discharges within six months of that annual administration, the instruments do not need to be re-administered. The last annual set will serve as the discharge set. On the other hand, if more than six months elapses between the annual administration and the client's discharge, a discharge set should be completed."*

- What if a client formally discharges from county services and a discharge set of instruments is completed and then, some time later, is readmitted? Do the instruments have to be re-administered as an intake set?

  It depends. The policy at this point is as follows: *"If a client completes a set of instruments at discharge and then is readmitted within six months, a new set of instruments does not need to be completed. This does not mean that a county or clinician may not chose to administer the instruments at this point, only that it is not required. If, however, the client is readmitted after more than six months has elapsed, a new set of instruments must be administered for the client."*

Billing for Instrument Administration, Scoring and Interpretation

- Is the time I spend administering and scoring the performance outcome instruments billable?

  Instrument administration and interpretation (clinician time). The time that a clinician spends assisting the client to complete the forms as well as the time spent reviewing the data resulting from the instruments is billable as part of the assessment under mental health services (for Medi-Cal eligible clients).

  Data input, system management, and report generation (clerical time). Time spent by clerical staff or another non-clinical county staff person to assist a client in completing the instrument, enter the data, score the instruments, and print reports, may be billable in a variety of ways. For example, some proportion of these services may be allocated as part of the client assessment costs for Medi-Cal

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eligible clients. However, billing for these services as part of the assessment may inflate a county's overall assessment rate causing it to exceed the Medi-Cal rate limit for assessments. These services may also be billable under quality improvement or utilization review billing codes on a dollar for dollar basis without impacting assessment rate limits.

Performance Outcomes and the Community Functioning Evaluation (CFE)

- Do the adult performance outcome instruments take the place of the Community Functioning Evaluation (CFE)?

  Yes. The State DMH is not requiring the CFE to be completed for those clients for whom the set of adult performance outcome instruments is completed. This policy was communicated to counties in APO Memo #99-02. However, if a target population client refuses to complete the set of adult performance outcome instruments, the CFE should be completed. Some counties, however, have decided to continue completing a CFE and are therefore doing both.

- What if a client fails to complete the entire set of instruments. Is there a minimum number of instruments that must be completed in order to waive the requirement for the CFE?

  After consulting with representatives from the California Mental Health Directors Association and the California Mental Health Planning Council, the DMH has agreed that, for adults, completion of either of the quality of life surveys (*CA-QOL* or *QL-SF*) is sufficient to fulfill the requirement for waiving the CFE.

- If I administer the adult performance outcome instruments to clients over 60 years of age, can I avoid completing the CFE for that client?

  No. The adult performance outcome instruments are intended to be completed for those target population clients who are ages 18 through 59. For clients 60 years of age and older, the DMH is pilot testing instruments that will take into account the specific and unique needs of older adults. This pilot is being conducted in association with the California Mental Health Directors Association, the California Mental Health Planning Council, Consumers and county staff. This Older Adult Performance Outcome System will be implemented some time in the year 2000.

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Confidentiality Procedures and Issues

- What kind of disclosure should be provided to the client regarding the performance outcome information, what is collected, how it will be used, and who will have access to it?

  Each county seems to be handling this issue in its own way. It is a good idea to introduce the performance outcome instruments to the client and explain exactly what they are intended to do. First, the instruments are a part of the assessment process. They help the clinician gain valuable insight into the client's life and functioning and will assist the clinician in learning how best to work with the client and plan their treatment. Second, it is good for the client to understand that the information will also be used, along with the responses of the rest of the county's adult clients with serious mental illnesses, to identify ways that services can be improved. Finally, the client should understand that the data will be reported to the State DMH which will use it to communicate to the State Legislature how effective county mental health programs are in helping clients improve. Clients are very likely to embrace the idea if they clearly understand the goals and benefits of the performance outcome system.

- If a client expresses concern about how confidential their responses are, what should I tell them?

  The information that they provide on the instruments is maintained in the client's file which already has certain protections for confidentiality. The data that are reported to the state for performance outcomes does not contain client names or addresses, but only demographic data and certain identifiers that will allow the outcome information to be linked to cost and service utilization data. At the county level, the outcome data are as secure as the billing and other service data that are maintained for the client. When it is reported to the state DMH, the information is encrypted in a manner that would make it extremely difficult for anyone to ever be able to read it without the appropriate password. At the state level, the data are maintained in secure computer systems with very limited access. Nobody from outside the department could get access to the data without first going through proper channels. Even then, identifying information would be stripped out so that the client's confidentiality would be protected.

- I notice that one of the pieces of information that is being requested is the client's social security number. Some clients and clinicians may feel uncomfortable reporting it. Why do you need it?

  In the best of all worlds, we would not be asking for social security number. Instead, we would simply rely on the client's county case number and the county

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code for the county where the services were provided in order to be able to link the outcome data with cost and service utilization data. However, DMH (as well as many other organizations) has found that there are often problems with linking files based only on client case number and county code. Some of these are as follows:

- When a client begins receiving services from a county provider, he or she receives a county case number. If the client discharges from that provider and begins being seen by another provider, he or she often receives a different case number. The problem, then, is that in a data base there would be two case numbers and both of them refer to a single individual. The only way that we could know this would be if we had a third identifier that was unique to the client. This is why we are requesting the client's social security number. The client's social security number is already reported to the DMH's Client Services Information System (CSI) for use in the same way.

- Another problem occurs when a client's case number was simply entered incorrectly at the county before the performance outcome data are reported to the State. Performance outcome staff will only discover the problem when they try to link responses on the performance outcome instruments to a client's service information. At that point, using the client's social security number, gender, ethnicity, and other information will be important for tracking down the correct client case number.

It must be emphasized that the client can request that his or her social security number not be included with their performance outcome data. It is not one of the fields that DMH is absolutely requiring in order to accept performance outcome data. It will only help us ensure that the data used are correct and that interpretations are valid.

- What if a client refuses to complete the adult performance outcome instruments?

It is not a requirement that a client complete the outcome instruments in order to receive services. It is their right to refuse to complete the instruments. Should a client refuse to complete the instruments, the refusal must be documented in the file. Some counties simply write across the front page of each instrument that was refused the words "CLIENT REFUSED."

It has been reported to DMH, however, that clients rarely refuse to complete the instruments, at least at intake. The greatest predictor of whether or not a client is willing to complete the instruments appears to be related to clinician attitude. If a clinician presents the instruments to a client in a manner that communicates that he of she feels it is a waste of time, the client will pick up on this. However, if the

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clinician communicates that he or she needs the information that the instruments provide in order to provide the most effective services AND that the information will be helpful to the county mental health program to improve its services, demonstrate its effectiveness, and thereby possibly increase its funding so it could provide additional services, the client is much more likely to participate.

- The MHSIP Consumer Survey collects pretty specific information regarding how the client feels about the services he or she is receiving. What should they be told about the confidentiality of their responses and how their responses will be used?

  The MHSIP Consumer Survey is unique among the adult performance outcome instruments. While the treating clinician will have access to the other instruments that the client completed (BASIS-32, Quality of Life Survey) including scored profiles and graphs, this is not the case with the MHSIP Consumer Survey.

  Because a client may feel that, in providing honest ratings on perceptions of care, he or she may be punished in some way or suffer retribution from a clinician or service provider who feels offended, a client's individual responses on the MHSIP should NEVER be provided to clinicians. Instead, clinicians must only receive aggregate responses that combine all of his or her clients. This will allow a clinician to see how their clients are perceiving the care they are receiving but will be unable to identify any single client. Thus, a client's responses will be kept confidential.

- I notice that DMH is collecting the client's case number on the MHSIP. Wouldn't it be better not to include it so that clients would know that nobody could identify their specific responses?

  Originally, the plan was to follow the lead of the Children's Performance Outcome System and give counties the option of either 1) including the client's case number so that DMH performance outcome staff could collect the appropriate demographic and service information from other systems or 2) not include the client's case number and instead provide the client's gender, age, ethnicity, and method of administration. However, the California Mental Health Planning Council (CMHPC), a group that is made up of over 50% direct consumers and family members as well as provider and county representatives and state-level staff, formally recommended that client case numbers be collected on the MHSIP. The DMH forwarded this request to the California Mental Health Director's Association which voted to accept the CMHPC's recommendation.

  The reason that the CMHPC requested the inclusion of client case numbers on the MHSIP is because this instrument collects far more than simple information on satisfaction with services. It also collects information on the client's perception

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of access to services, the appropriateness of services received, and the client's perception of the outcomes of those services. The CMHPC believes (and the DMH concurs) that having the ability to link this information with the client's actual outcome data as well as other system level data such as cost of services and service utilization patterns is critical to fully understanding the outcomes of California's public mental health system.

- I am from a small county with very few clients. Even if I provide a clinician with aggregate scores on the MHSIP for his or her clients, the clinician will probably be able to identify the individual respondents. How should I handle this?

  This is a really good question and raises an important point. In small counties or in programs where a particular sub-group of individuals is very small, a simple average of scores for groups is not appropriate. For example, if a county or program has only one African American client and average scores by ethnicity are provided to clinicians, the scores of the African American will be obvious. The same could be true with low numbers for gender, age, or diagnostic category. In such situations, the aggregation of data must be expanded. In the worst case scenario, data might be reported by "Whites" and "Non-Whites" or perhaps "Schizophrenia" and "All other disorders." The key is to use common sense.

- Can you describe some of the administration procedures that counties have used to administer the MHSIP Consumer Survey so that client confidentiality is ensured?

  One important procedure that many counties follow is to provide clients with a written statement (and possibly read it with them) that explains that their responses to the MHSIP will be kept confidential. The client should be clear that his or her responses will not be directly shared with his or her clinician. The statement should note that their responses will only be used to evaluate and improve the services they are receiving and will in no way affect the availability of services or their own access to services.

  ## Services Provided in a Clinic

  There are several ways that counties have administered the MHSIP in the clinic setting. These include:

  - Before the client sees his or her clinician, a clerical staff person fills in the required identification information (e.g., client case number, county code, link date) and then hands the MHSIP to the client for completion along with an envelope in which to seal the survey. Upon completing the survey and sealing

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it in an envelope, the consumer drops the envelope in a locked box. Later, the surveys are retrieved and the data entered. It appears that this is the most effective way to collect this information and ensure a high return rate the and most representative sample for the MHSIP.

- A clerical staff person fills in the required identification information (e.g., client case number, county code, link date) on the MHSIP and provides it to a clinician sometime before the client is to be seen. After the client has finished a session, the clinician hands the MHSIP to the client and asks him or her to complete it before leaving the clinic and drop it in the locked box in the lobby. Some argue that this makes the clinician too much a part of the process and could cause some clients to distrust that their responses will be kept confidential.

- A clerical staff person fills in the required identification information (e.g., client case number, county code, link date) on the MHSIP and provides it to a clinician along with a self-addressed stamped envelope sometime before the client is to be seen. After the client has finished a session, the clinician hands the MHSIP to the client and asks him or her to complete it and drop it in the mail later. Some counties have expressed that they have found that clients tend not to return surveys through the mail. Responses could also be biased in that only individuals who are either very satisfied or not satisfied at all might respond.

- A clerical staff person fills in the required identification information (e.g., client case number, county code, link date) on the MHSIP and mails it to the client along with a cover letter and self-addressed stamped envelope about the time the client is scheduled for an annual case review. Some counties have tried this method and found that clients tend not to return surveys through the mail. Also, responses could be biased in that only individuals who are either very satisfied or not satisfied at all might respond.

Services Provided in the Home

- Prior to a clinician making a home visit, a clerical staff person fills in the required identification information (e.g., client case number, county code, link date) on the MHSIP and provides it to the clinician along with an envelope in which to seal the survey once it is complete. Before beginning the session, the clinician asks the client to complete the MHSIP while the clinician occupies him or herself doing other things (paperwork, etc.). Upon completion of the MHSIP, the clinician asks the client to seal the MHSIP in the envelope (some have even suggested asking the client to sign across the sealed portion as a

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guard against tampering). The clinician collects the sealed envelope and, after the session is complete, drops it in a locked box back at the clinic. This method, similar to one of the methods used in a clinic setting, is perhaps the best for ensuring a high return rate and the most valid sample.

- Prior to a clinician making a home visit, a clerical staff person fills in the required identification information (e.g., client case number, county code, link date) on the MHSIP and provides it to the clinician along with a self-addressed stamped envelope in which to seal the survey once it is complete. Before beginning the session, the clinician asks the client to complete the MHSIP while the clinician occupies him or herself doing other things (paperwork, etc.). Upon completion of the MHSIP, the clinician asks the client to seal the MHSIP in the envelope (some have even suggested asking the client to sign across the sealed portion as a guard against tampering). The client is then asked to place the envelope in the mail where it will be returned to county administration for data entry and analysis.

- Prior to a clinician making a home visit, a clerical staff person fills in the required identification information (e.g., client case number, county code, link date) on the MHSIP and provides it to the clinician along with a self addressed stamped envelope in which to seal the survey once it is complete. After the home visit is concluded, the MHSIP and envelope are provided to the client and the client is asked to complete the survey at their convenience and place it in the mail. According to county staff, this is not a very effective way to ensure a high return rate and the sample is likely to be biased.

Issues for Small Counties Reporting Data Through DMH's TELEform System

- I understand that DMH has implemented a TELEform, fax-based system that some counties use to report their performance outcome data. Is my county eligible for this?

  Counties whose total population is 50,000 or less are eligible to use the DMH TELEform fax back system. In general these counties know who they are. If you have questions about whether or not your county is eligible, you may contact Ann Brito at (916) 653-0706.

- How does the DMH TELEform system work?

  After the adult performance outcome survey forms and face sheets have been completed, the forms are faxed to DMH at a special phone number. The forms

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are then read into a computer program that automatically converts the survey responses into an electronic format. For those counties eligible to use the DMH system, faxing in forms in this manner fulfills their performance outcome data reporting requirements. DMH will then send counties a diskette with a carefully encrypted file that a the small county can import into the Adult Performance Outcome Data System (APODS), which is an Access database developed by DMH, and from there, the county can print out reports for clinicians to use in treatment planning as well as print out system reports that show how the county is doing overall.

- Are there any special things I need to do if we are going to use the DMH TELEform system?

Yes. It is very important that you do the following

1. Make sure your fax machine is properly maintained. This includes cleaning it regularly.
2. Make sure that the fax machine is set to *high resolution*. This will ensure that the most quality image is sent to DMH and will greatly improve the efficiency of our automated reading system.
3. You do not need to have clients use a #2 pencil to complete the forms. Actually, we have found that ink, especially black ink or felt tip pens are the best writing instruments to use to fill in the bubbles on the survey forms.
4. Before faxing the forms to DMH, someone should review the pages of the surveys to check for overall quality. If parts of the forms are not complete, the forms should be returned to the clinician to try and assist the client to finish the forms.
5. Before faxing the forms, it is very important to look in the lower left hand corner of the forms. You should see a set of nine boxes with the title "Form Linking Number." The clients id number should be entered in these boxes ON EACH PAGE of the survey. This helps our TELEform system to know which pages go together. For example, if you fax the pages out of order, or if one page gets separated from the others, the Form Linking Number will allow us to properly bring the pages back together.

Reporting Performance Outcome Data to the State Department of Mental Health

- How does the performance outcome data get reported to the State?

Regardless of the data system you use at the county level to maintain your performance outcome data, when you export the data to report to the state, you must ensure that it is formatted according to the file structure identified in the

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Adult Performance Outcome System Data Dictionary. This is very important. If the data you report is not in this format, it will be returned to the county for correction. Should you require a copy of the data dictionary, contact Roxane Gomez at (916) 654-0471.

The files that are sent to the state are ASCII fixed field format. Before the files are sent to the state, they are to be encrypted with a password that will be provided to your county by State DMH Information Technology staff. Next, the files will be uploaded to DMH using the Department's electronic bulletin board. For more information regarding the data uploading procedure, contact Loren Rubenstein, Information Technology at (916) 654-6249.

- How frequently does the data get reported to DMH?

Our ultimate goal is to have data that are current enough that DMH performance outcome staff are able to provide reports to county that are timely and informative. To do this, DMH needs to have data that are relatively current. During the early months of the implementation of the Adult Performance Outcome System, data reporting will be quarterly. Once we are sure that the counties have worked out any data reporting issues and/or problems, data reporting will be every six months.

- How will DMH release the data?

The DMH will not release an individual county's data to others until the county has first had a chance to review it for accuracy and to provide additional interpretation. Data will be sent to the county mental health director and a copy to the county's Adult Program Coordinator with a request for comments on accuracy, etc. The initial reports sent out will show regional and statewide averages, with each county getting a copy of its own individual results.

Technology Issues

- What technology should my county invest in to handle our performance outcome data?

It is not appropriate for the State Department of Mental Health to recommend any single software vendor to counties as a source for technology to handle their data. This is because it could lead to accusations that the DMH is favoring one software package over another. Therefore, performance outcome staff have simply tried to pass along information from vendors that have contacted them or about systems that individual counties have purchased.

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- Have any alternative systems been identified that counties can consider and how can I find out more about them?

  Yes. A number of alternatives have presented themselves. They are not the only ones that should be considered and no one system is appropriate for all counties. Some of these systems, along with how to contact their vendors, are listed below.

  - Adult Performance Outcome Data System (APODS)
    Developed by State DMH Information Technology staff and consultants. Includes screens for manual data entry, imports data from files that meet the format requirements of the Adult Performance Outcome Data Dictionary, generates graphs and charts for clinicians including global narrative reports, generates system level reports including demographics for non-duplicated clients, and global reports for each instrument for use in decision support, exports data in a format compliant with the Adult Performance Outcome Data Dictionary for easy reporting to the DMH.

    For a copy of the APODS program, contact Traci Fujita at (916) 653-3300 or email her at tfujita@dmhhq.ca.state.gov

  - HCIA /Response Technology
    Includes screens for manual data entry, includes an electronic card scanner for automated data entry, generates graphs and charts for clinicians, generates system level reports for each instrument for use in decision support, exports data in a format compliant with the Adult Performance Outcome Data Dictionary for easy reporting to the DMH. For information regarding this product, contact Deborah Rearick at (781) 522-4630 or e-mail her at drear@hcia.com

  - TELE*form*
    TELE*form* is not a data management system. Instead, it is a way of automating data entry. It allows a person to use a standard fax machine as a scanner. Essentially, the way counties (as well as DMH performance outcome staff) have used TELE*form* is to have a clinician or clerical staff person fax completed outcome instruments to a central computer that has the TELE*form* program loaded on it. When the fax arrives on the computer, TELE*form* reads it and converts the data into an electronic format and exports it into a specified database. This database could be in Microsoft Access, FoxPro, Excel, SPSS, or a wide variety of other formats. If the user has adequate technical sophistication, TELE*form* can be set up to score the instruments and fax back reports to the clinician that sent the original fax for use in treatment planning. For information regarding this product, contact Cardiff Software at (800) 659-8755 or e-mail at support@cardiffsw.com

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- IVR
  Interactive Voice Response (IVR) is an automated telephone system for administering questionnaires. For information regarding this product, contact Dr. Benjamin Brodey, Director of Research at Medassure IVR at (206) 917-5076 or e-mail at brodey@medassure.net

- EFI
  EVAL-FLEX, Inc. (EFI) uses touchscreen technology, the Internet, and Interactive Voice Response systems for both client self-administered information and for staff input of client relevant data. For information regarding this product, contact Dr. Michael McGuire, President and CEO of EFI at (818) 808-1390 or e-mail at information@evalflex.com

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